EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
NORTHERN DIVISION

ABRIELLE LONDO, Plaintiff, v. ENRIGHT FAMILY RESTAURANTS, INC., and STEPHEN WHELAN, Defendants.	Case No.: 2:20-cv-53 U.S. District Judge: Hon. Paul L. Maloney U.S. Magistrate Judge: Hon. Maarten Vermaat

DEFENDANTS' SECOND REQUESTS FOR PRODUCTION OF DOCUMENTS TO PLAINTIFF

NOW COME Defendants, Enright Family Restaurants, Inc. and Stephen Whelan, by and through their attorneys, Numinen, DeForge & Toutant, P.C., and for Defendants' Requests for Production of Documents to Plaintiff, state the following:

Pursuant to Federal Rules of Civil Procedure 26 and 34 Plaintiff Abrielle Londo shall, within thirty (30) days, produce copies of the following documents at 105 Meeske Ave., Marquette, MI 49855.

The term "documents" is defined to have the same meaning and to be equal in scope to the terms "documents" and "electronically stored information" as used in Federal Rule of Civil Procedure (34)(a).

REQUESTS FOR PRODUCTION OF DOCUMENTS

1. Please execute and return the attached authorizations for the release of health, employment and other information.

Respectfully submitted,

Numinen, DeForge & Toutant, P.C.

Date: May 12, 2021

PHILLIP B. TOUTANT (P72992)
Attorney for Plaintiff
105 Meeske Ave.
Marquette, MI 49855
(906) 226-2580

PROOF OF SERVICE

The undersigned certifies that a copy of the foregoing instrument was served upon the attorneys of record of all parties to the above cause of action by mailing via U.S.P.S. First Class Mail, of the same to them at their respective business addresses as disclosed by the pleadings of record herein on May 12, 2021.

LAUREN A. PETERS
NUMINEN, DeFORGE & TOUTANT, P.C.

RELEASE OF INFORMATION

Medical Record #_____ (Office Use Only)

(Required items are in **BOLD** print — *Please do not use correction fluid or tape)*

Patient Name: Abrielle Londo **Date of Birth:**___/___/___

Previous Names:_____ **Social Security #:** ___/___/___

Address:_____ **City, State & Zip Code:** _____ **Phone #:** _____

I, Abrielle Londo authorize UP Health Systems

Name of Patient or Name of Legal Representative *Name of Organization/Provider to Release Information*

850 West Baraga Ave	Marquette, MI 49855	906-449-1510	906-449-1811
Address	*City, State and Zip Code*	*Phone Number*	*Fax Number*

to release information concerning the patient identified above, in accordance with state and federal laws, to the following:

Numinen, DeForge & Toutant, P.C.

Name/Organization to Receive Information

105 Meeske Ave.	Marquette, MI 49855	906-226-2580	906-226-2248
Address	*City, State and Zip Code*	*Phone Number*	*Fax Number*

1. **Specific information to be disclosed** *(check all that apply)*

☐ Discharge Summary	☐ Psychological Evaluations	☐ Progress Notes	☐ Substance Abuse
☐ History & Physical Examination	☐ Lab Reports	☐ Radiology/X-ray Films	☐ Consultation Reports
☐ EKG/Stress Test	☐ Emergency Room Record	☐ Radiology/X-ray Reports	☐ Operative/Procedure Reports
		☐ Discharge Instructions	☐ Home Health

Other:_____

For the following date(s) of treatment or medical conditions: _____

2. With the exception of psychotherapy notes, I authorize all information which may be contained in my medical records pertaining to psychiatric/ mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released **unless** otherwise specified here: _____

3. **I am requesting this information be released for the following purpose:**
   ☐ Continued Care ☐ Insurance Claim ☐ Personal Use ☒ Attorney Review
   ☐ Other _____
4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
5. I understand there may be a fee to process this release of information.
6. This authorization will automatically expire on: ___/___/___ or one year from the date of my signature.
7. UP Health System - Marquette will not condition my continued treatment upon my signing this authorization, except for research-related treatment.
8. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving Party and may no longer be protected by Federal or State law, unless protected by Federal Regulation 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the receiving Party without my written authorization.
9. I hereby agree to indemnify and hold UP Health System - Marquette, their employees and agents free and harmless from any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.

_____ _____
Patient or Patient's Legal Representative's Signature *Date*

_____ _____
**Relationship If Other Than Patient* *Witness*

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other: _____

*☐ **AUTHORITY ATTACHED** (In non-emergency situations documentation of authority must be attached if anyone other than the patient signs this authorization).

UP HEALTH SYSTEM MARQUETTE
A Duke LifePoint Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

ROI-0001 (4/03, Rev. 12/14)
MRURsubApprove: 12/17/14

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, Abrielle Londo, authorize the following person or entity:

Name:_____ Address:_____
_____ to disclose protected health information of:

Name: Abrielle Londo

Address:_____

City/State/Zip _____ Telephone #_____

Social Security #: XXX-XX-_____ Health Record #: _____

D.O.B.: _____

to Numinen, DeForge & Toutant, P.C., and its client, to use and disclose for record review in connection with pending litigation.

I understand this authorization allows disclosure and use of my PHI which is protected under federal and state law, including records regarding alcohol and drug treatment, mental health care, communicable diseases and infections, venereal disease, tuberculosis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS-related complex (ARC) and other personal information.

I understand authorizing the disclosure of PHI is voluntary and that I can refuse to sign this authorization.

I understand any and all PHI is to be disclosed.

I understand I may revoke this authorization at any time. However, any revocation must be written, signed by me, dated, and sent to Numinen, DeForge & Toutant, P.C., and, will not affect any actions Numinen, DeForge & Toutant, P.C., took before they received the revocation. This authorization will expire one (1) year from the date I sign it, unless I specify it expires after the following date or event

I understand the PHI disclosed may not be re-released without my authorization or appropriate court order. However, any disclosure of information carries the potential for unauthorized re-disclosure where the information would no longer be protected by law.

I understand the person or entity I authorize to disclose PHI by this authorization will not condition my care, treatment, or any payment, enrollment in a health plan or eligibility for benefits on my providing this authorization.

Patient signature:_____ Date: _____

AUTHORIZATION TO DISCLOSE INFORMATION

I, Abrielle Londo, authorize the following person or entity:
Name:_____ Address:_____
to disclose information of or relating to:

Name: Abrielle Londo
Address:_____
City/State/Zip_____ Telephone #:_____
Social Security #: _____ Health Record #:_____
D.O.B.: _____

to Numinen, DeForge & Toutant, P.C., 105 Meeske Ave., Marquette, MI 49855 and its client, to use and disclose for record review in connection with pending litigation.

I understand authorizing the disclosure of information is voluntary and that I can refuse to sign this authorization.

I understand any and all information is to be disclosed.

Signature:_____ Date:_____